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WORLD CONFERENCE AGAINST RACISM, RACIAL DISCRIMINATION, XENOPHOBIA AND RELATED INTOLERANCE

Preparatory Committee
Inter-sessional open-ended working group
Geneva, 6 - 9 March 2001

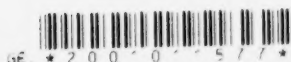
Item 4 of the provisional agenda

DRAFT DECLARATION AND PROGRAMME OF ACTION OF THE WORLD CONFERENCE

Contribution*/ submitted by Physicians for Human Rights

The Secretary-General has received the following contribution which is circulated in accordance with Economic and Social Council resolution 1996/31.

*/This contribution is issued, unedited, as received from the submitting non-governmental organization(s)



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PHYSICIANS FOR HUMAN RIGHTS

Statement to the The Inter-sessional Working Group

UN World Conference Against Racism, Racial Discrimination, Xenophobia And Related Intolerance

Racial and Ethnic Disparities in Diagnosis and Treatment in Health Care: The United States Example

National policies forbidding racial discrimination have been enshrined in US civil rights laws and have essentially eliminated de jure discrimination in the United States. Nevertheless, Physicians for Human Rights (PHR) is aware that race and ethnicity still play a pervasive role in social, economic and political practices in the US. It is therefore with disappointment, though not surprise, that PHR notes that racial and ethnic biases have manifested themselves in the US health care system.

PHR is deeply concerned about the existence of compelling evidence that racial and ethnic minorities have a poorer health status than their white counterparts in the US. The poorer health status of minority populations in the US is primarily attributable to environmental factors (social, physical, biologic, economic and political) as well as to lack of access to medical care. However, even more disturbing is the fact that a significant contribution to this differential in health status is made by racial/ethnic disparities in the diagnosis and treatment of patients already in the US health care system.

There has been a plethora of studies that support the existence of racial and ethnic disparities. The topics of these studies include a wide spectrum of diseases and medical and surgical practice as well as such related issues as cultural competency training in the health professions, cross-racial/ethnic physician-patient communication, patient trust in the health care system, and institutional racism. In most such studies, African-American and, to a less well-documented extent, Hispanics and Native Americans, received less care, and less intensive care, than white patients.

This pattern was found not only for such high-technology interventions as coronary artery bypass grafting, advanced cancer treatment, renal transplantation, or hip and knee replacement, but also even in basic elements of clinical care such as the adequacy of physical examinations, physical histories, and laboratory tests

In the 1990s many studies were conducted which adequately controlled or adjusted for the confounding variables of health insurance status, income, education, severity of disease, comorbidity and hospital type. In some studies, denial of advanced treatment or procedures was shown to disproportionately affect African-Americans with severe diseases who were most likely to benefit from these procedures. Additionally, the 5-year survival rate for black patient groups was significantly lower than the survival rate for white patient groups in the same time period.

The most frequently cited explanations for these differentials were patient choice, alleged cultural beliefs of minority patients, lack of trust in the health care system, or unmeasured socioeconomic variables assumed to be associated with race. However, some recent prospective studies, permitting detailed examination of medical records and interviews with patients and decision-making physicians, have found that patient choice accounted for only a small percentage of the differentials in diagnosis and treatment.

For example, one study of coronary artery disease found that physicians believed their denials of advanced treatment (angioplasty or bypass grafting) to minority patients were based on assessments of the state of the disease or its prognosis. However, the data strongly suggested that physicians unconsciously projected negative racial stereotypes onto these patients, and that such stereotypes were predictive of their treatment recommendations. Another recent study examined the outcomes in a series of several hundred cases in which patients' race was not included in the otherwise complete clinical material presented to decision-making physicians. When the race variable was absent, there was no difference in the treatment recommendations given to the patients.

Physicians for Human Rights believes that such practices, whether covert or overt, conflict most profoundly with the egalitarian and humanitarian commitments of the medical profession and with the ideals of fairness and equality which should be the guiding principles in the management of illness, pain and suffering.

Physicians for Human Rights also strongly believes that the evidence of racial disparities in the US healthcare system runs afoul the United States' obligations under several international human rights instruments including: Article 25(1) of the Universal Declaration of Human Rights, Article 5(e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination, and the non-discrimination clauses of the International Covenant on Civil and Political Rights.

Physicians for Human Rights

Racial and Ethnic Disparities in Diagnosis and Treatment in Health Care

PHR strongly endorses the views expressed by the Committee on Economic, Social and Cultural Rights in its General Comment No. 14 wherein the Committee proclaims universal entitlement to "the enjoyment of the highest attainable standard of health conducive to living a life of dignity."

PHR recognizes that race and ethnicity remain powerful and often divisive social factors both nationally and globally. However, PHR believes that a vigorous and coordinated effort by the international community can help to ameliorate circumstances in which biases prevent racial and ethnic minorities from equal enjoyment of the right to health (as recognized by the Commission on Human Rights, the Human Rights Committee and as proclaimed in the Vienna Declaration and Programme of Action).

PHR believes that candid discussion among countries that have vulnerable minority groups about the existence of racial and/or ethnic disparities in their health care systems is a necessary first step to eradicating the problem.

PHR therefore welcomes the opportunity to discuss the prevalence of this problem in other countries. PHR is interested in sharing information and expertise with governmental, non-governmental and professional organizations and agencies with a view to cooperative engagement toward eradicating racial and ethnic biases in the provision of health care.

PHR suggests that all countries initiate quality assurance programs and that those states which are vulnerable to this problem require systematic monitoring for racial/ethnic differentials in treatment patterns as part of quality assurance programs of all organized systems of medical care.

PHR notes that most current cultural competency training available for physicians in the US is limited in scope, does not usually address provider bias, and in some instances may reinforce stereotypic thinking. PHR proposes that the appropriate agencies ensure that cultural sensitivity programs are continuous throughout the undergraduate and graduate years of medical and other health professional training. In the US, for example, these courses should address issues of covert provider bias, and should be required for the accreditation of health professional schools.

Physicians for Human Rights
Racial and Ethnic Disparities in Diagnosis and Treatment in Health Care

PHR strongly encourages the United States to sign, ratify and strictly adhere to the Convention on Economic Social and Cultural Rights. This is one of several means to ensure that health care is available and accessible on an equal basis for racial and ethnic minorities in the US

PHR strongly believes that health is an essential precursor to the enjoyment of all other human rights. If there is discrimination in the provision of health care, then racial and ethnic minorities will never be able to fully enjoy the inalienable rights they share with all other members of the human family. These rights have been recognized by the international community and encoded into international law. PHR believes that the Declaration and Program of Action resulting from the UN World Conference Against Racism, Racial Discrimination, Xenophobia and Related Intolerance is a timely opportunity for the world community take concrete steps toward alleviating this problem worldwide.